Reprinted
April 15, 2009

ENGROSSED
HOUSE BILL No. 1572

DIGEST OF HB 1572 (Updated April 14, 2009 3:44 pm - DI 104)

Citations Affected: IC 2-5; IC 12-13; IC 23-2; noncode.

Synopsis: Medicaid matters. Requires the health finance commission to study all aspects of the health facility quality assessment fee. Requires the health policy advisory committee to submit an annual report to the health finance commission on the committee's findings and recommendations. Revises the definition of "continuing care agreement". Specifies when a person providing continuing care has to register the continuing care retirement community with the securities commissioner. Eliminates payments to the Indiana retirement home guaranty fund after June 30, 2009. Removes provisions limiting the health facilities subject to the quality assessment fee based on the health facility's Medicaid utilization rate and annual Medicaid revenue. Eliminates the exemption from the quality assessment fee for health facilities that only receive Medicare revenues. Provides an exemption for hospital based health facilities. Specifies conditions that a

(Continued next page)

Effective: Upon passage; October 1, 2008 (retroactive); January 1, 2009 (retroactive); July 1, 2009.

Welch, Brown C, Crawford, Turner
(SENATE SPONSORS — MILLER, ERRINGTON)

January 16, 2009, read first time and referred to Committee on Public Health.
February 19, 2009, amended, reported — Do Pass.
February 23, 2009, read second time, ordered engrossed. Engrossed.
February 25, 2009, read third time, passed. Yeas 97, nays 1.

SENATE ACTION
March 3, 2009, read first time and referred to Committee on Health and Provider Services.
April 9, 2009, amended, reported favorably — Do Pass.
April 14, 2009, read second time, amended, ordered engrossed.

Digest Continued

continuing care retirement community must meet in order to be exempt from the quality assessment fee. Eliminates the role of the department of state revenue in collecting quality assessment fees. Specifies the percentage distribution of money collected from the quality assessment depending on whether the state is receiving an adjusted federal medical assistance percentage by the federal American Recovery and Reinvestment Act of 2009. Extends the health facility quality assessment fee until August 1, 2011. (The fee currently expires August 1, 2009.) Requires that certain contractors for: (1) the division of family resources; (2) the office of Medicaid policy and planning; and (3) the office of the secretary of family and social services; that process eligibility intake information for the federal supplemental nutrition assistance program (SNAP), the temporary assistance to needy families (TANF) program, and the Medicaid program review certain intake statistics and provide certain information to the select joint commission on Medicaid oversight. Establishes the Medicaid managed care quality strategy committee to study issues related to Medicaid managed care.

Reprinted
April 15, 2009

First Regular Session 116th General Assembly (2009)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2008 Regular Session of the General Assembly.

ENGROSSED
HOUSE BILL No. 1572

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 2-5-23-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 4. **(a)** The commission may study any topic:

(1) directed by the chairman of the commission;

(2) assigned by the legislative council; or

(3) concerning issues that include:

(A) the delivery, payment, and organization of health care services;

(B) rules adopted under IC 4-22-2 that pertain to health care delivery, payment, and services that are under the authority of any board or agency of state government; and

(C) the implementation of IC 12-10-11.5.

(b) The commission shall study all aspects of the health facility quality assessment fee collected by the office of Medicaid policy and planning.

SECTION 2. IC 2-5-23-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. ~~Beginning May 1, 1997,~~ **(a)**

The health policy advisory committee is established. At the request of the chairman **of the commission,** the health policy advisory committee shall provide information and otherwise assist the commission to perform the duties of the commission under this chapter.

(b) The health policy advisory committee members are ex officio and may not vote.

(c) The health policy advisory committee members shall be appointed from the general public and must include one (1) individual who represents each of the following:

(1) The interests of public hospitals.

(2) The interests of community mental health centers.

(3) The interests of community health centers.

(4) The interests of the long term care industry.

(5) The interests of health care professionals licensed under IC 25, but not licensed under IC 25-22.5.

(6) The interests of rural hospitals. An individual appointed under this subdivision must be licensed under IC 25-22.5.

(7) The interests of health maintenance organizations (as defined in IC 27-13-1-19).

(8) The interests of for-profit health care facilities (as defined in IC 27-8-10-1).

(9) A statewide consumer organization.

(10) A statewide senior citizen organization.

(11) A statewide organization representing people with disabilities.

(12) Organized labor.

(13) The interests of businesses that purchase health insurance policies.

(14) The interests of businesses that provide employee welfare benefit plans (as defined in 29 U.S.C. 1002) that are self-funded.

(15) A minority community.

(16) The uninsured. An individual appointed under this subdivision must be and must have been chronically uninsured.

(17) An individual who is not associated with any organization, business, or profession represented in this subsection other than as a consumer.

(d) The chairman of the commission shall annually select a member of the health policy advisory committee to serve as chairperson.

(e) The health policy advisory committee shall meet at the call of the chairperson of the health policy advisory committee.

(f) The health policy advisory committee shall submit an annual

report not later than September 15 of each year to the commission that summarizes the committee's actions and the committee's findings and recommendations on any topic assigned to the committee. The report must be in an electronic format under IC 5-14-6.

SECTION 3. IC 12-13-5-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: **Sec. 14. (a) As used in this section, "commission" refers to the select joint commission on Medicaid oversight (IC 2-5-26-3).**

(b) A contractor for the division, office, or secretary that has responsibility for processing eligibility intake for the federal Supplemental Nutrition Assistance program (SNAP), the Temporary Assistance for Needy Families (TANF) program, and the Medicaid program shall do the following:

(1) Review the eligibility intake process for:

(A) document management issues, including:

(i) unattached documents;

(ii) number of documents received by facsimile;

(iii) number of documents received by mail;

(iv) number of documents incorrectly classified;

(v) number of documents that are not indexed or not correctly attached to cases;

(vi) number of complaints from clients regarding lost documents; and

(vii) number of complaints from clients resolved regarding lost documents;

(B) direct client assistance at county offices, including the:

(i) number of clients helped directly in completing eligibility application forms;

(ii) wait times at local offices;

(iii) amount of time an applicant is given as notice before a scheduled applicant appointment;

(iv) amount of time an applicant waits for a scheduled appointment; and

(v) timeliness of the tasks sent by the contractor to the state for further action, as specified through contracted performance standards; and

(C) call wait times and abandonment rates.

(2) Provide an update on employee training programs.

(3) Provide a copy of the monthly key performance indicator report.

(4) Provide information on error reports and contractor

compliance with the contract.

(5) Provide oral and written reports to the commission concerning matters described in subdivision (1):

(A) in a manner and format to be agreed upon with the commission; and

(B) whenever the commission requests.

(c) Solely referring an individual to a computer or telephone does not constitute the direct client assistance referred to in subsection (b)(1)(B).

SECTION 4. IC 23-2-4-1, AS AMENDED BY P.L.27-2007, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 1. As used in this chapter, the term:

"Application fee" means the fee charged an individual, in addition to the entrance fee or any other fee, to cover the provider's reasonable costs in processing the individual's application to become a resident.

"Commissioner" means the securities commissioner as provided in IC 23-19-6-1(a).

"Continuing care agreement" means **the following:**

(1) For continuing care retirement communities registered before July 1, 2009, an agreement by a provider to furnish to ~~at least one (1)~~ **an** individual, for the payment of an entrance fee **of at least twenty-five thousand dollars ($25,000)** and periodic charges:

(A) accommodations in a living unit of a ~~home and.~~ **continuing care retirement community;**

~~(1)~~ **(B)** meals and related services;

~~(2)~~ **(C)** nursing care services;

~~(3)~~ **(D)** medical services;

~~(4)~~ **(E)** other health related services; or

~~(5)~~ **(F)** any combination of these services;

for the life of the individual or for more than one (1) month, **unless the agreement is cancelled.**

(2) For continuing care retirement communities registered after June 30, 2009, an agreement by a provider to furnish to an individual, for the payment of an entrance fee of at least twenty-five thousand dollars ($25,000) and periodic charges:

(A) accommodations in a living unit of a continuing care retirement community;

(B) meals and related services;

(C) nursing care services;

(D) medical services;

(E) other health related services; or

(F) any combination of these services;

for the life of the individual, unless the agreement is terminated as specified under this chapter.

"Continuing care retirement community" includes both of the following:

(1) An independent living facility.

(2) A health facility licensed under IC 16-28.

"Contracting party" means a person or persons who enter into a continuing care agreement with a provider.

"Entrance fee" means the sum of money or other property paid or transferred, or promised to be paid or transferred, to a provider in consideration for one (1) or more individuals becoming a resident of a ~~home~~ **continuing care retirement community** under a continuing care agreement.

~~"Home" means a facility where the provider undertakes, pursuant to a continuing care agreement, to provide continuing care to five (5) or more residents.~~

"Living unit" means a room, apartment, cottage, or other area within a ~~home~~ **continuing care retirement community** set aside for the use of one (1) or more identified residents.

"Long term financing" means financing for a period in excess of one (1) year.

"Omission of a material fact" means the failure to state a material fact required to be stated in any disclosure statement or registration in order to make the disclosure statement or registration, in light of the circumstances under which they were made, not misleading.

"Person" means an individual, a corporation, a partnership, an association, a limited liability company, or other legal entity.

"Provider" means a person that agrees to provide ~~continuing~~ care ~~to an individual~~ under a continuing care agreement.

"Refurbishment fee" means the fee charged an individual, in addition to the entrance fee or any other fee, to cover the provider's reasonable costs in refurbishing a previously occupied living unit specifically designated for occupancy by that individual.

"Resident" means an individual who is entitled to receive benefits under a continuing care agreement.

"Solicit" means any action of a provider in seeking to have an individual residing in Indiana pay an application fee and enter into a continuing care agreement, including:

(1) personal, telephone, or mail communication or any other communication directed to and received by any individual in

Indiana; and

(2) advertising in any media distributed or communicated by any means to individuals residing in Indiana.

"Termination" refers to the cancellation of a continuing care agreement under this chapter.

SECTION 5. IC 23-2-4-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 2. This chapter applies to any person who:

(1) enters into a continuing care agreement in Indiana to provide care at a ~~home~~ **continuing care retirement community** located either inside Indiana or outside Indiana;

(2) enters into a continuing care agreement outside Indiana to provide care at a ~~home~~ **continuing care retirement community** located in Indiana;

(3) extends the term of an existing continuing care agreement in Indiana to provide care at a ~~home~~ **continuing care retirement community** located either inside Indiana or outside Indiana;

(4) extends the term of an existing continuing care agreement outside Indiana to provide care at a ~~home~~ **continuing care retirement community** located in Indiana; or

(5) solicits the execution of a continuing care agreement by persons in Indiana.

SECTION 6. IC 23-2-4-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 3. (a) A provider shall register each ~~home~~ **continuing care retirement community** with the commissioner **if:**

(1) before opening the continuing care retirement community, the provider:

(A) enters into;

(B) extends; or

(C) solicits;

a continuing care agreement; or

(2) while operating the continuing care retirement community, the provider has entered into a continuing care agreement with at least twenty-five percent (25%) of the individuals living in the continuing care retirement community.

(b) If a provider fails to register a ~~home,~~ **continuing care retirement community,** the provider may not:

(1) enter into, or extend the term of, a continuing care agreement to provide continuing care to any person at that ~~home,~~ **continuing care retirement community;**

(2) provide services at that ~~home~~ **continuing care retirement community** under a continuing care agreement; or

(3) solicit the execution, by persons residing within Indiana, of a continuing care agreement to provide continuing care at that ~~home.~~ **continuing care retirement community.**

~~(b)~~ **(c)** The provider's application for registration must be filed with the commissioner by the provider on forms prescribed by the commissioner, and must be accompanied by an application fee of two hundred fifty dollars ($250). The application must contain the following information:

(1) an initial disclosure statement, as described in section 4 of this chapter; and

(2) any other information required by the commissioner under rules adopted under this chapter.

~~(c)~~ **(d)** The commissioner may accept, in lieu of the information required by subsection ~~(b),~~ **(c),** any other registration, disclosure statement, or other document filed by the provider in Indiana, in any other state, or with the federal government if the commissioner determines that such document substantially complies with the requirements of this chapter.

~~(d)~~ **(e)** Upon receipt of the application for registration, the commissioner shall mark the application filed. Within sixty (60) days of the filing of the application, the commissioner shall enter an order registering the provider or rejecting the registration. If no order of rejection is entered within that sixty (60) day period, the provider shall be considered registered unless the provider has consented in writing to an extension of time; if no order of rejection is entered within the time period as extended by consent, the provider shall be considered registered.

~~(e)~~ **(f)** If the commissioner determines that the application for registration complies with all of the requirements of this chapter, the commissioner shall enter an order registering the provider. If the commissioner determines that such requirements have not been met, the commissioner shall notify the provider of the deficiencies and shall inform the provider that it has sixty (60) days to correct them. If the deficiencies are not corrected within sixty (60) days, the commissioner shall enter an order rejecting the registration. The order rejecting the registration shall include the findings of fact upon which the order is based. The provider may petition for reconsideration, and is entitled to a hearing upon that petition.

SECTION 7. IC 23-2-4-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 4. The

initial disclosure statement shall contain the following information:

(1) The name and business address of the provider.

(2) If the provider is a partnership, corporation, limited liability company, or association, the names and duties of its officers, directors, trustees, partners, members, or managers.

(3) The name and business address of any person having a five percent (5%) or greater ownership interest in the provider or manager of the ~~home.~~ **continuing care retirement community.**

(4) A description of the business experience of the provider and its officers, directors, trustees, partners, or managers.

(5) A statement as to whether the provider or any of its officers, directors, trustees, partners, or managers, within ten (10) years prior to the date of the initial disclosure statement:

(A) was convicted of a crime;

(B) was a party to any civil action for fraud, embezzlement, fraudulent conversion, or misappropriation of property that resulted in a judgment against ~~him;~~ **the provider or individual;**

(C) had a prior discharge in bankruptcy or was found insolvent in any court action; or

(D) had any state or federal licenses or permits suspended or revoked in connection with any health care or continuing care activities, or related business activities.

(6) The identity of any other ~~home~~ **continuing care retirement community** currently or previously operated by the provider or manager of the ~~home.~~ **continuing care retirement community.**

(7) The location and description of other properties, both existing and proposed, of the provider in which the provider owns a twenty-five percent (25%) ownership interest, and on which ~~homes~~ **continuing care retirement communities** are or are intended to be located.

(8) A statement as to whether the provider is, or is affiliated with, a religious, charitable, or other nonprofit association, and the extent to which the affiliate organization is responsible for the financial and contractual obligations of the provider.

(9) A description of all services to be provided by the provider under its continuing care agreements with contracting parties, and a description of all fees for those services, including conditions under which the fees may be adjusted.

(10) A description of the terms and conditions under which the continuing care agreement can be cancelled, or fees refunded.

(11) Financial statements of the provider prepared in accordance

with generally accepted accounting principles applied on a consistent basis and certified by an independent certified or public accountant, including a balance sheet as of the end of the provider's last fiscal year and income statements for the last three (3) fiscal years, or such shorter period of time as the provider has been in operation.

(12) If the operation of the ~~home~~ **continuing care retirement community** has not begun, a statement of the anticipated source and application of funds to be used in the purchase or construction of the ~~home,~~ **continuing care retirement community,** and an estimate of the funds, if any, which are anticipated to be necessary to pay for start-up losses.

(13) A copy of the forms of agreement for continuing care used by the provider.

(14) Any other information that the commissioner may require by rule or order.

SECTION 8. IC 23-2-4-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 5. (a) Each year after the initial year in which a ~~home~~ **continuing care retirement community** is registered under section 3 of this chapter, the provider shall file with the commissioner within four (4) months after the end of the provider's fiscal year, unless otherwise extended by the written consent of the commissioner, an annual disclosure statement which shall consist of the financial information set forth in section 4(11) of this chapter.

(b) The annual disclosure statement required to be filed with the commissioner under this section shall be accompanied by an annual filing fee of one hundred dollars ($100).

SECTION 9. IC 23-2-4-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 6. (a) A provider shall amend its initial or annual disclosure statement filed with the commissioner under section 3 and section 5 of this chapter at any time if necessary to prevent the initial or annual disclosure statement from containing any material misstatement of fact or omission of a material fact.

(b) Upon the sale of a ~~home~~ **continuing care retirement community** to a new provider, the new provider shall amend the currently filed disclosure statement to reflect the fact of sale and any other fact that would be required to be disclosed under section 4 of this chapter if the new provider were filing an initial disclosure statement.

SECTION 10. IC 23-2-4-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE

JANUARY 1, 2009 (RETROACTIVE)]: **Sec. 7.5. (a) This section does not apply to a continuing care retirement community registered before July 1, 2009.**

(b) A continuing care agreement may be terminated for any of the following reasons:

(1) The provider has determined that the resident is inappropriate for living in the care setting.

(2) The resident is unable to fully pay the periodic charges because the resident inappropriately divested the assets and income the resident identified at the time of admission to meet the ordinary and customary living expenses for the resident.

(3) Providing assistance to the resident would jeopardize the financial solvency of the provider and the other residents being served by the provider.

(4) The resident has requested a termination of the agreement as allowed under the agreement.

SECTION 11. IC 23-2-4-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 10. (a) Except as provided by section 11 of this chapter, the commissioner shall require, as a condition of registration, that:

(1) the provider establish an interest-bearing escrow account with a bank, trust company, or other escrow agent approved by the commissioner; and

(2) any entrance fees received by the provider prior to the date the resident is permitted to occupy the living unit in the ~~home~~ **continuing care retirement community** be placed in the escrow account, subject to release as provided by subsection (b).

(b) If the entrance fee gives the resident the right to occupy a living unit that has been previously occupied, the entrance fee and any income earned thereon shall be released to the provider when the living unit is first occupied by the new resident. If the entrance fee applies to a living unit that has not been previously occupied by any resident, the entrance fee and any income earned thereon shall be released to the provider when the commissioner is satisfied that:

(1) aggregate entrance fees received or receivable by the provider pursuant to executed continuing care agreements, plus:

(A) anticipated proceeds of any first mortgage loan or other long term financing commitment; and

(B) funds from other sources in the actual possession of the provider;

are equal to at least fifty percent (50%) of the aggregate cost of constructing, purchasing, equipping, and furnishing the ~~home~~

continuing care retirement community and equal to at least fifty percent (50%) of the estimate of funds necessary to fund startup losses of the ~~home,~~ **continuing care retirement community,** as reported under section 4(12) of this chapter; and

(2) a commitment has been received by the provider for any permanent mortgage loan or other long term financing described in the statement of anticipated source and application of funds to be used in the purchase or construction of the ~~home~~ **continuing care retirement community** under section 4(12) of this chapter, and any conditions of the commitment prior to disbursement of funds thereunder, other than completion of the construction or closing of the purchase of the ~~home,~~ **continuing care retirement community,** have been substantially satisfied.

(c) If the funds in an escrow account under this section and any interest earned thereon are not released within the time provided by this section or by rules adopted by the commissioner, then the funds shall be returned by the escrow agent to the persons who made the payment to the provider.

(d) An entrance fee held in escrow shall be returned by the escrow agent to the person who paid the fee in the following instances:

(1) At the election of the person who paid the fee, at any time before the fee is released to the provider under subsection (b).

(2) Upon receipt by the escrow agent of notice from the provider that the person is entitled to a refund of the entrance fee.

(e) This section does not require a provider to place a nonrefundable application fee charged to prospective residents in escrow.

(f) A provider is not required to place a refurbishment fee of a prospective resident in escrow if a continuing care agreement provides that the prospective resident:

(1) will occupy the living unit within sixty (60) days after the refurbishment fee is paid; and

(2) will receive a refund of any portion of the refurbishment fee not expended for refurbishment if the continuing care agreement is cancelled before occupancy.

SECTION 12. IC 23-2-4-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 12. Any money or property received by a provider as an entrance fee to a ~~home~~ **continuing care retirement community** constructed or purchased after August 31, 1982, or any income earned thereon, may be used by the provider only for purposes directly related to the construction, maintenance, or operation of that particular ~~home.~~ **continuing care retirement community.** A ~~home~~ **continuing care**

retirement community in operation on September 1, 1982, may not use the entrance fees or income earned thereon after August 31, 1982, for the construction, operation, or maintenance of another ~~home~~ **continuing care retirement community** constructed or purchased after August 31, 1982.

SECTION 13. IC 23-2-4-13, AS AMENDED BY P.L.2-2006, SECTION 180, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 13. (a) There is established the Indiana retirement home guaranty fund. The purpose of the fund is to provide a mechanism for protecting the financial interests of residents and contracting parties in the event of the bankruptcy of the provider.

(b) To create the fund, a guaranty association fund fee of one hundred dollars ($100) shall be levied on each contracting party who enters into a continuing care agreement after August 31, 1982, **and before July 1, 2009.** The fee shall be collected by the provider and forwarded to the commissioner within thirty (30) days after occupancy by the resident. Failure of the provider to collect and forward such fee to the commissioner within that thirty (30) day period shall result in the imposition by the commissioner of a twenty-five dollar ($25) penalty against the provider. In addition, interest payable by the provider shall accrue on the unpaid fee at the rate of two percent (2%) a month.

(c) Any money received by the commissioner under subsection (b) shall be forwarded to the treasurer of state. The fund, and any income from it, shall be held in trust, deposited in a segregated account, invested and reinvested by the treasurer of state in the same manner as provided in IC 20-49-3-10 for investment of the common school fund.

(d) All reasonable expenses of collecting and administering the fund shall be paid from the fund.

(e) Money in the fund at the end of the state's fiscal year shall remain in the fund and shall not revert to the general fund.

SECTION 14. IC 23-2-4-16 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 16. (a) If a ~~home~~ **continuing care retirement community** is bankrupt and the operation of the ~~home~~ **continuing care retirement community** is terminated, the board of directors shall, subject to the approval of the commissioner, distribute from the guaranty association fund established in section 13 to the living residents of the ~~home~~ **continuing care retirement community** an aggregate amount not to exceed one-half (1/2) of the amount in the fund at the time of disbursement. The amount each living resident is entitled to receive shall be prorated, based on the total amount paid on behalf of the resident by the contracting party under the continuing care agreement.

In no event may the amount paid to an individual resident under this section exceed the total amount paid on behalf of that resident under the continuing care agreement, less the total value of services received under the agreement.

(b) Any living resident of the ~~home~~ **continuing care retirement community** shall be eligible to receive distributions under subsection (a), regardless of whether any contribution to the guaranty association fund has been made on behalf of the resident.

(c) A resident compensated under this section assigns ~~his~~ **the resident's** rights under the continuing care agreement, to the extent of compensation received under this section, to the board of directors on behalf of the fund. The board of directors may require an assignment of those rights by a resident to the board, on behalf of the fund, as a condition precedent to the receipt of compensation under this section. The board of directors, on behalf of the fund, is subrogated to these rights against the assets of a bankrupt or dissolved provider. Any monies or property collected by the board of directors under this subsection shall be deposited in the fund.

(d) The subrogation rights of the board of directors, on behalf of the fund, have the same priority against the assets of the bankrupt or dissolved provider as those possessed by the resident under the continuing care agreement.

SECTION 15. IC 23-2-4-21 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 21. If the commissioner has reason to believe that a ~~home~~ **continuing care retirement community** is insolvent, the commissioner may petition the superior or circuit court of the county in which the ~~home~~ **continuing care retirement community** is located, or the superior or circuit court of Marion County, for the appointment of a receiver to assume the management and possession of the ~~home~~ **continuing care retirement community** and its assets.

SECTION 16. P.L.3-2007, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE OCTOBER 1, 2008 (RETROACTIVE)]: SECTION 1. (a) **As used in this SECTION, "continuing care retirement community" means a health care facility that:**

(1) provides independent living services and health facility services in a campus setting with common areas;

(2) holds continuing care agreements with at least twenty-five percent (25%) of its residents (as defined in IC 23-2-4-1);

(3) uses the money described in subdivision (2) to provide services to the resident before the resident may be eligible for Medicaid under IC 12-15; and

(4) meets the requirements of IC 23-2-4.

(b) As used in this SECTION, "health facility" refers to a health facility that is licensed under IC 16-28 as a comprehensive care facility.

~~(b)~~ **(c)** As used in this SECTION, "nursing facility" means a health facility that is certified for participation in the federal Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

~~(c)~~ **(d)** As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

~~(d) As used in this SECTION, "total annual revenue" does not include revenue from Medicare services provided under Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).~~

(e) Effective August 1, ~~2003,~~ **2009,** the office shall collect a quality assessment from each ~~nursing~~ **health** facility. ~~that has:~~

~~(1) a Medicaid utilization rate of at least twenty-five percent (25%); and~~

~~(2) at least seven hundred thousand dollars ($700,000) in annual Medicaid revenue; adjusted annually by the average annual percentage increase in Medicaid rates.~~

The office shall offset the collection of the assessment for a health facility:

(1) against a Medicaid payment to the health facility by the office; or

(2) in another manner determined by the office.

(f) ~~If~~ **The office shall implement the waiver approved by** the United States Centers for Medicare and Medicaid Services ~~determines not to approve payments under this SECTION using the methodology described in subsection (e), the office shall revise the state plan amendment and waiver request submitted under subsection (l) as soon as possible to demonstrate compliance with 42 CFR 433.68(e)(2)(ii). The revised state plan amendment and waiver request must provide~~ **that provides** for ~~the following:~~

~~(1) Effective August 1, 2003, collection of a quality assessment by the office from each nursing facility.~~

~~(2) Effective August 1, 2003, collection of a quality assessment by the department of state revenue from each health facility that is not a nursing facility.~~

~~(3) An~~ **an** exemption from collection of a quality assessment from the following:

~~(A)~~

(1) A continuing care retirement community **as follows:**

(A) A continuing care retirement community that was

registered with the securities commissioner as a continuing care retirement community on January 1, 2007, is not required to meet the definition of a continuing care retirement community in subsection (a).

(B) A continuing care retirement community that, for the period January 1, 2007, through June 30, 2009, operates independent living units, at least twenty-five percent (25%) of which are provided under contracts that require the payment of a minimum entrance fee of at least twenty-five thousand dollars ($25,000).

(C) An organization registered under IC 23-2-4 before July 1, 2009, that provides housing in an independent living unit for a religious order.

(D) A continuing care retirement community that meets the definition set forth in subsection (a).

~~(B) A health facility that only receives revenue from Medicare services provided under 42 U.S.C. 1395 et seq.~~

~~(C)~~

(2) A **hospital based** health facility. ~~that has less than seven hundred fifty thousand dollars ($750,000) in total annual revenue, adjusted annually by the average annual percentage increase in Medicaid rates.~~

~~(D)~~

(3) The Indiana Veterans' Home.

Any revision to the state plan amendment or waiver request under this subsection is subject to and must comply with the provisions of this SECTION.

(g) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under this SECTION using the methodology described in subsections **(d) and** (e), ~~and (f),~~ the office shall revise the state plan amendment and waiver request submitted under ~~subsection (l)~~ **this SECTION** as soon as possible to demonstrate compliance with 42 CFR 433.68(e)(2)(ii) and to provide for collection of a quality assessment from health facilities effective August 1, ~~2003.~~ **2009.** ~~In amending the state plan amendment and waiver request under this subsection, the office may modify the parameters described in subsection (f)(3). However, if the office determines a need to modify the parameters described in subsection (f)(3), the office shall modify the parameters in order to achieve a methodology and result as similar as possible to the methodology and result described in subsection (f). Any revision of the state plan amendment and waiver request under this subsection is subject to and must comply with the provisions of~~

~~this SECTION.~~

(h) The money collected from the quality assessment may be used only to pay the state's share of the costs for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) as follows:

(1) **At the following percentages when the state's regular federal medical assistance percentage (FMAP) applies, excluding the time frame in which the adjusted FMAP is provided to the state by the federal American Recovery and Reinvestment Act of 2009:**

(A) Twenty percent (20%) as determined by the office.

~~(2)~~ **(B)** Eighty percent (80%) to nursing facilities.

(2) At the following percentages when the state's federal medical assistance percentage (FMAP) is adjusted by the federal American Recovery and Reinvestment Act of 2009:

(A) Forty percent (40%) as determined by the office.

(B) Sixty percent (60%) to nursing facilities.

(i) After:

(1) the amendment to the state plan and waiver request submitted under this SECTION is approved by the United States Centers for Medicare and Medicaid Services; and

(2) the office calculates and begins paying enhanced reimbursement rates set forth in this SECTION;

the office ~~and the department of state revenue~~ shall begin the collection of the quality assessment set under this SECTION. The office ~~and the department of state revenue shall~~ **may** establish a method to allow a facility to enter into an agreement to pay the quality assessment collected under this SECTION subject to an installment plan.

(j) If federal financial participation becomes unavailable to match money collected from the quality assessments for the purpose of enhancing reimbursement to nursing facilities for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the office ~~and department of state revenue~~ shall cease collection of the quality assessment under this SECTION.

(k) To implement this SECTION, the

~~(1)~~ office shall adopt rules under IC 4-22-2. ~~and~~

~~(2) office and department of state revenue shall adopt joint rules under IC 4-22-2.~~

(l) Not later than ~~July 1, 2003,~~ **August 1, 2009,** the office shall do the following:

(1) Request the United States Department of Health and Human Services under 42 CFR 433.72 to approve waivers of 42 CFR

433.68(c) and 42 CFR 433.68(d) by demonstrating compliance with 42 CFR 433.68(e)(2)(ii).

(2) Submit any state Medicaid plan amendments to the United States Department of Health and Human Services that are necessary to implement this SECTION.

(m) After approval of the waivers and state Medicaid plan amendment applied for under ~~subsection (l),~~ **this SECTION,** the office ~~and the department of state revenue~~ shall implement this SECTION effective ~~July 1, 2003.~~ **August 1, 2009.**

(n) The select joint commission on Medicaid oversight, established by IC 2-5-26-3, shall review the implementation of this SECTION. The office may not make any change to the reimbursement for nursing facilities unless the select joint commission on Medicaid oversight recommends the reimbursement change.

(o) A nursing facility or a health facility may not charge the facility's residents for the amount of the quality assessment that the facility pays under this SECTION.

(p) The office may withdraw a state plan amendment **submitted** under ~~subsection (e), (f), or (g)~~ **this SECTION** only if the office determines that failure to withdraw the state plan amendment will result in the expenditure of state funds not funded by the quality assessment.

(q) If a health facility fails to pay the quality assessment under this SECTION not later than ten (10) days after the date the payment is due, the health facility shall pay interest on the quality assessment at the same rate as determined under IC 12-15-21-3(6)(A).

(r) The ~~following shall be provided to the state department of health:~~

~~(1) The~~ office shall report **to the state department of health** each nursing **facility and each health** facility that fails to pay the quality assessment under this SECTION not later than one hundred twenty (120) days after payment of the quality assessment is due.

~~(2) The department of state revenue shall report each health facility that is not a nursing facility that fails to pay the quality assessment under this SECTION not later than one hundred twenty (120) days after payment of the quality assessment is due.~~

(s) The state department of health shall do the following:

(1) Notify each nursing facility and each health facility reported under subsection (r) that the nursing facility's or health facility's license under IC 16-28 will be revoked if the quality assessment is not paid.

(2) Revoke the nursing facility's or health facility's license under

IC 16-28 if the nursing facility or the health facility fails to pay the quality assessment.

(t) An action taken under subsection (s)(2) is governed by:

(1) IC 4-21.5-3-8; or

(2) IC 4-21.5-4.

(u) The office shall report the following information to the select joint commission on Medicaid oversight established by IC 2-5-26-3 at every meeting of the commission:

(1) Before the quality assessment is approved by the United States Centers for Medicare and Medicaid Services:

(A) an update on the progress in receiving approval for the quality assessment; and

(B) a summary of any discussions with the United States Centers for Medicare and Medicaid Services.

(2) After the quality assessment has been approved by the United States Centers for Medicare and Medicaid Services:

(A) an update on the collection of the quality assessment;

(B) a summary of the quality assessment payments owed by a nursing facility or a health facility; and

(C) any other relevant information related to the implementation of the quality assessment.

(v) This SECTION expires August 1, ~~2009.~~ **2011.**

SECTION 17. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "committee" refers to the Medicaid managed care quality strategy committee created by this SECTION.**

(b) The Medicaid managed care quality strategy committee is created to provide information on policy issues concerning Medicaid. The committee shall study issues related to the following:

(1) Emergency room utilization.

(2) Prior authorization.

(3) Standardization of procedures, forms, and service descriptions.

(4) Effectiveness and quality of care.

(c) The members of the committee shall include at least one (1) individual representing each of the following:

(1) Medicaid providers.

(2) Public hospitals.

(3) Medicaid managed care organizations.

(4) Mental health professions.

(5) The office of Medicaid policy and planning, who shall act as chairperson of the committee.

(6) Other state agencies.

The governor shall appoint the committee members. The committee may not consist of more than seven (7) members.

(d) The office of the secretary of family and social services shall staff the committee.

(e) The affirmative votes of a majority of the members are required for the committee to take make recommendations.

(f) Before October 1, 2009, the committee shall report to the select joint commission on Medicaid oversight established by IC 2-5-26-3 concerning the committee's recommendations.

(g) This SECTION expires December 31, 2009.

SECTION 18. **An emergency is declared for this act.**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1572, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, delete lines 1 through 15, begin a new paragraph and insert:

"SECTION 1. IC 2-5-23-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. ~~Beginning May 1, 1997,~~ **(a)** The health policy advisory committee is established. At the request of the chairman **of the commission,** the health policy advisory committee shall provide information and otherwise assist the commission to perform the duties of the commission under this chapter.

(b) The health policy advisory committee members are ex officio and may not vote.

(c) The health policy advisory committee members shall be appointed from the general public and must include one (1) individual who represents each of the following:

(1) The interests of public hospitals.

(2) The interests of community mental health centers.

(3) The interests of community health centers.

(4) The interests of the long term care industry.

(5) The interests of health care professionals licensed under IC 25, but not licensed under IC 25-22.5.

(6) The interests of rural hospitals. An individual appointed under this subdivision must be licensed under IC 25-22.5.

(7) The interests of health maintenance organizations (as defined in IC 27-13-1-19).

(8) The interests of for-profit health care facilities (as defined in IC 27-8-10-1).

(9) A statewide consumer organization.

(10) A statewide senior citizen organization.

(11) A statewide organization representing people with disabilities.

(12) Organized labor.

(13) The interests of businesses that purchase health insurance policies.

(14) The interests of businesses that provide employee welfare benefit plans (as defined in 29 U.S.C. 1002) that are self-funded.

(15) A minority community.

(16) The uninsured. An individual appointed under this subdivision must be and must have been chronically uninsured.

(17) An individual who is not associated with any organization,

business, or profession represented in this subsection other than as a consumer.

(d) The chairman of the commission shall annually select a member of the health policy advisory committee to serve as chairperson.

(e) The health policy advisory committee shall meet at the call of the chairperson of the health policy advisory committee.

(f) The health policy advisory committee shall submit quarterly reports to the commission and the select joint commission on Medicaid oversight that summarize the committee's actions and the committee's findings and recommendations on any topic assigned to the committee. The report must be in an electronic format under IC 5-14-6.".

Page 2, line 2, reset in roman "may".

Page 2, line 2, delete "shall".

Page 2, line 5, delete "each managed care provider" and insert "**the office shall establish a uniformed prescription drug formulary to be administered and managed by the Medicaid managed care companies. Each managed care provider that has contracted with the office under IC 12-15-30 shall submit to the office recommendations of prescription drugs to be added to the formulary. The office shall use its discretion to determine the process for review, edits, and additions to the formulary as required by the drug utilization review board. The prescription drug formulary is not required to be the same as the drug utilization review board's preferred drug list established by IC 12-15-35.**".

Page 2, delete lines 6 through 10.

Page 2, line 28, delete "the following".

Page 3, delete lines 19 through 42.

Delete pages 4 through 5.

Page 6, delete lines 1 through 41, begin a new paragraph and insert:

"SECTION 7. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "advisory committee" refers to the health policy advisory committee established by IC 2-5-23-8.**

(b) Before July 1, 2010, the advisory committee shall study and make recommendations concerning the following:

(1) Whether the office of Medicaid policy and planning should expedite review of an infant's placement and determine that the infant is at a level of institutionalization that would qualify the child for federal Supplemental Security Income in situations in which an infant:

(A) is a patient in, or is anticipated to need care in, a neonatal or perinatal intensive care setting for at least thirty (30) days; or

(B) has an illness that falls in the diagnosis related group (DRG) category list used by the office that would qualify the infant as disabled.

(2) Whether the office of Medicaid policy and planning should publish on the office's web site the diagnosis related group (DRG) category list used by the office in subdivision (1)(B).

(3) The minimum time needed to conduct an expedited review under subdivision (1).

(4) The uniform definitions that a managed care organization that has contracted with the office under IC 12-15-30 must have, including the following terms:

(A) "Administrative denial".

(B) "Appeal".

(C) "Complaint".

(D) "Grievance".

(E) "Inquiry".

(F) "Medical necessity denial".

(G) "Reconsideration".

(H) Any other definitions outlined by the National Commission on Quality Assurance.

(5) The uniform procedures that a managed care organization that has contracted with the office under IC 12-15-30 must have, including a uniform procedure for the following:

(A) Credentialing that allows a provider to be credentialed one (1) time for participation in any Medicaid program.

(B) Claims processing.

(6) The uniform process and form to be used by managed care organizations that have contracted with the office of Medicaid policy and planning under IC 12-15-30, including the following forms:

(A) A denial of a claim form.

(B) An appeals process form.

(C) A prior authorization form.

(D) Any other forms that are necessary for consistency and standardization according to National Commission on Quality Assurance accreditation criteria.

(7) The prevalence of reclassification of an initial request made by a provider, including a request for appeal.

(8) Simplified uniform reporting criteria for the following:

(A) Pharmacy claim reviews, including denials, appeals, and overturns.

(B) Medical necessary prior authorization approvals, denials, and overturns.

(C) Administrative denials, appeals, and overturns.

(9) The current state data reporting metrics.

(10) Any needed revisions to the reporting requirements to comply with the National Commission on Quality Assurance reporting and outcome standards.

(c) Before June 1, 2009:

(1) the president pro tempore of the senate shall appoint members of the advisory committee as required under IC 2-5-23-9; and

(2) the speaker of the house of representatives shall appoint members of the advisory committee as required under IC 2-5-23-10.

(d) This SECTION expires July 1, 2010.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1572 as introduced.)

BROWN C, Chair

Committee Vote: yeas 11, nays 0.

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1572, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 2-5-23-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 4. **(a)** The commission may study any topic:

(1) directed by the chairman of the commission;

(2) assigned by the legislative council; or

(3) concerning issues that include:

(A) the delivery, payment, and organization of health care

services;

(B) rules adopted under IC 4-22-2 that pertain to health care delivery, payment, and services that are under the authority of any board or agency of state government; and

(C) the implementation of IC 12-10-11.5.

(b) The commission shall study all aspects of the health facility quality assessment fee collected by the office of Medicaid policy and planning.".

Page 2, line 27, delete "quarterly" and insert "**an annual report not later than September 15 of each year**".

Page 2, line 28, delete "reports".

Page 2, line 28, delete "and the select joint commission on".

Page 2, line 29, delete "Medicaid oversight".

Page 2, line 29, delete "summarize" and insert "**summarizes**".

Page 2, delete lines 33 through 42, begin a new paragraph and insert:

"SECTION 3. IC 12-13-5-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: **Sec. 14. (a) As used in this section, "commission" refers to the select joint commission on Medicaid oversight (IC 2-5-26-3).**

(b) A contractor for the division, office, or secretary that has responsibility for processing eligibility intake for the federal Supplemental Nutrition Assistance program (SNAP), the Temporary Assistance for Needy Families (TANF) program, and the Medicaid program shall do the following:

(1) Review the eligibility intake process for:

(A) document management issues, including:

(i) unattached documents;

(ii) number of documents received by facsimile;

(iii) number of documents received by mail;

(iv) number of documents incorrectly classified;

(v) number of documents that are not indexed or not correctly attached to cases;

(vi) number of complaints from clients regarding lost documents; and

(vii) number of complaints from clients resolved regarding lost documents;

(B) direct client assistance at county offices, including the:

(i) number of clients helped directly in completing eligibility application forms;

(ii) wait times at local offices;

(iii) amount of time an applicant is given as notice before

a scheduled applicant appointment;

(iv) amount of time an applicant waits for a scheduled appointment; and

(v) timeliness of the tasks sent by the contractor to the state for further action, as specified through contracted performance standards; and

(C) call wait times and abandonment rates.

(2) Provide an update on employee training programs.

(3) Provide a copy of the monthly key performance indicator report.

(4) Provide information on error reports and contractor compliance with the contract.

(5) Provide oral and written reports to the commission concerning matters described in subdivision (1):

(A) in a manner and format to be agreed upon with the commission; and

(B) whenever the commission requests.

(c) Solely referring an individual to a computer or telephone does not constitute the direct client assistance referred to in subsection (b)(1)(B).

SECTION 4. IC 23-2-4-1, AS AMENDED BY P.L.27-2007, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 1. As used in this chapter, the term:

"Application fee" means the fee charged an individual, in addition to the entrance fee or any other fee, to cover the provider's reasonable costs in processing the individual's application to become a resident.

"Commissioner" means the securities commissioner as provided in IC 23-19-6-1(a).

"Continuing care agreement" means **the following:**

(1) For continuing care retirement communities registered before July 1, 2009, an agreement by a provider to furnish to ~~at least one (1)~~ **an** individual, for the payment of an entrance fee **of at least twenty-five thousand dollars ($25,000)** and periodic charges:

(A) accommodations in a living unit of a ~~home and:~~ **continuing care retirement community;**

~~(1)~~ **(B)** meals and related services;

~~(2)~~ **(C)** nursing care services;

~~(3)~~ **(D)** medical services;

~~(4)~~ **(E)** other health related services; or

~~(5)~~ **(F)** any combination of these services;

for the life of the individual or for more than one (1) month, **unless the agreement is cancelled.**

(2) For continuing care retirement communities registered after June 30, 2009, an agreement by a provider to furnish to an individual, for the payment of an entrance fee of at least twenty-five thousand dollars ($25,000) and periodic charges:

(A) accommodations in a living unit of a continuing care retirement community;

(B) meals and related services;

(C) nursing care services;

(D) medical services;

(E) other health related services; or

(F) any combination of these services;

for the life of the individual, unless the agreement is terminated as specified under this chapter.

"Continuing care retirement community" includes both of the following:

(1) An independent living facility.

(2) A health facility licensed under IC 16-28.

"Contracting party" means a person or persons who enter into a continuing care agreement with a provider.

"Entrance fee" means the sum of money or other property paid or transferred, or promised to be paid or transferred, to a provider in consideration for one (1) or more individuals becoming a resident of a ~~home~~ **continuing care retirement community** under a continuing care agreement.

~~"Home" means a facility where the provider undertakes, pursuant to a continuing care agreement, to provide continuing care to five (5) or more residents.~~

"Living unit" means a room, apartment, cottage, or other area within a ~~home~~ **continuing care retirement community** set aside for the use of one (1) or more identified residents.

"Long term financing" means financing for a period in excess of one (1) year.

"Omission of a material fact" means the failure to state a material fact required to be stated in any disclosure statement or registration in order to make the disclosure statement or registration, in light of the circumstances under which they were made, not misleading.

"Person" means an individual, a corporation, a partnership, an association, a limited liability company, or other legal entity.

"Provider" means a person that agrees to provide ~~continuing~~ care ~~to an individual~~ under a continuing care agreement.

"Refurbishment fee" means the fee charged an individual, in addition to the entrance fee or any other fee, to cover the provider's reasonable costs in refurbishing a previously occupied living unit specifically designated for occupancy by that individual.

"Resident" means an individual who is entitled to receive benefits under a continuing care agreement.

"Solicit" means any action of a provider in seeking to have an individual residing in Indiana pay an application fee and enter into a continuing care agreement, including:

(1) personal, telephone, or mail communication or any other communication directed to and received by any individual in Indiana; and

(2) advertising in any media distributed or communicated by any means to individuals residing in Indiana.

"Termination" refers to the cancellation of a continuing care agreement under this chapter.

SECTION 5. IC 23-2-4-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 2. This chapter applies to any person who:

(1) enters into a continuing care agreement in Indiana to provide care at a ~~home~~ **continuing care retirement community** located either inside Indiana or outside Indiana;

(2) enters into a continuing care agreement outside Indiana to provide care at a ~~home~~ **continuing care retirement community** located in Indiana;

(3) extends the term of an existing continuing care agreement in Indiana to provide care at a ~~home~~ **continuing care retirement community** located either inside Indiana or outside Indiana;

(4) extends the term of an existing continuing care agreement outside Indiana to provide care at a ~~home~~ **continuing care retirement community** located in Indiana; or

(5) solicits the execution of a continuing care agreement by persons in Indiana.

SECTION 6. IC 23-2-4-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 3. (a) A provider shall register each ~~home~~ **continuing care retirement community** with the commissioner **if:**

(1) before opening the continuing care retirement community, the provider:

(A) enters into;

(B) extends; or

(C) solicits;

a continuing care agreement; or

(2) while operating the continuing care retirement community, the provider has entered into a continuing care agreement with at least twenty-five percent (25%) of the individuals living in the continuing care retirement community.

(b) If a provider fails to register a ~~home,~~ **continuing care retirement community,** the provider may not:

(1) enter into, or extend the term of, a continuing care agreement to provide continuing care to any person at that ~~home,~~ **continuing care retirement community;**

(2) provide services at that ~~home~~ **continuing care retirement community** under a continuing care agreement; or

(3) solicit the execution, by persons residing within Indiana, of a continuing care agreement to provide continuing care at that ~~home.~~ **continuing care retirement community.**

~~(b)~~ **(c)** The provider's application for registration must be filed with the commissioner by the provider on forms prescribed by the commissioner, and must be accompanied by an application fee of two hundred fifty dollars ($250). The application must contain the following information:

(1) an initial disclosure statement, as described in section 4 of this chapter; and

(2) any other information required by the commissioner under rules adopted under this chapter.

~~(c)~~ **(d)** The commissioner may accept, in lieu of the information required by subsection ~~(b),~~ **(c),** any other registration, disclosure statement, or other document filed by the provider in Indiana, in any other state, or with the federal government if the commissioner determines that such document substantially complies with the requirements of this chapter.

~~(d)~~ **(e)** Upon receipt of the application for registration, the commissioner shall mark the application filed. Within sixty (60) days of the filing of the application, the commissioner shall enter an order registering the provider or rejecting the registration. If no order of rejection is entered within that sixty (60) day period, the provider shall be considered registered unless the provider has consented in writing to an extension of time; if no order of rejection is entered within the time period as extended by consent, the provider shall be considered registered.

~~(e)~~ **(f)** If the commissioner determines that the application for registration complies with all of the requirements of this chapter, the

commissioner shall enter an order registering the provider. If the commissioner determines that such requirements have not been met, the commissioner shall notify the provider of the deficiencies and shall inform the provider that it has sixty (60) days to correct them. If the deficiencies are not corrected within sixty (60) days, the commissioner shall enter an order rejecting the registration. The order rejecting the registration shall include the findings of fact upon which the order is based. The provider may petition for reconsideration, and is entitled to a hearing upon that petition.

SECTION 7. IC 23-2-4-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 4. The initial disclosure statement shall contain the following information:

(1) The name and business address of the provider.

(2) If the provider is a partnership, corporation, limited liability company, or association, the names and duties of its officers, directors, trustees, partners, members, or managers.

(3) The name and business address of any person having a five percent (5%) or greater ownership interest in the provider or manager of the ~~home.~~ **continuing care retirement community.**

(4) A description of the business experience of the provider and its officers, directors, trustees, partners, or managers.

(5) A statement as to whether the provider or any of its officers, directors, trustees, partners, or managers, within ten (10) years prior to the date of the initial disclosure statement:

(A) was convicted of a crime;

(B) was a party to any civil action for fraud, embezzlement, fraudulent conversion, or misappropriation of property that resulted in a judgment against ~~him;~~ **the provider or individual;**

(C) had a prior discharge in bankruptcy or was found insolvent in any court action; or

(D) had any state or federal licenses or permits suspended or revoked in connection with any health care or continuing care activities, or related business activities.

(6) The identity of any other ~~home~~ **continuing care retirement community** currently or previously operated by the provider or manager of the ~~home.~~ **continuing care retirement community.**

(7) The location and description of other properties, both existing and proposed, of the provider in which the provider owns a twenty-five percent (25%) ownership interest, and on which ~~homes~~ **continuing care retirement communities** are or are intended to be located.

(8) A statement as to whether the provider is, or is affiliated with, a religious, charitable, or other nonprofit association, and the extent to which the affiliate organization is responsible for the financial and contractual obligations of the provider.

(9) A description of all services to be provided by the provider under its continuing care agreements with contracting parties, and a description of all fees for those services, including conditions under which the fees may be adjusted.

(10) A description of the terms and conditions under which the continuing care agreement can be cancelled, or fees refunded.

(11) Financial statements of the provider prepared in accordance with generally accepted accounting principles applied on a consistent basis and certified by an independent certified or public accountant, including a balance sheet as of the end of the provider's last fiscal year and income statements for the last three (3) fiscal years, or such shorter period of time as the provider has been in operation.

(12) If the operation of the ~~home~~ **continuing care retirement community** has not begun, a statement of the anticipated source and application of funds to be used in the purchase or construction of the ~~home,~~ **continuing care retirement community,** and an estimate of the funds, if any, which are anticipated to be necessary to pay for start-up losses.

(13) A copy of the forms of agreement for continuing care used by the provider.

(14) Any other information that the commissioner may require by rule or order.

SECTION 8. IC 23-2-4-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 5. (a) Each year after the initial year in which a ~~home~~ **continuing care retirement community** is registered under section 3 of this chapter, the provider shall file with the commissioner within four (4) months after the end of the provider's fiscal year, unless otherwise extended by the written consent of the commissioner, an annual disclosure statement which shall consist of the financial information set forth in section 4(11) of this chapter.

(b) The annual disclosure statement required to be filed with the commissioner under this section shall be accompanied by an annual filing fee of one hundred dollars ($100).

SECTION 9. IC 23-2-4-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 6. (a) A provider shall amend its initial or annual disclosure statement filed

with the commissioner under section 3 and section 5 of this chapter at any time if necessary to prevent the initial or annual disclosure statement from containing any material misstatement of fact or omission of a material fact.

(b) Upon the sale of a ~~home~~ **continuing care retirement community** to a new provider, the new provider shall amend the currently filed disclosure statement to reflect the fact of sale and any other fact that would be required to be disclosed under section 4 of this chapter if the new provider were filing an initial disclosure statement.

SECTION 10. IC 23-2-4-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: **Sec. 7.5. (a) This section does not apply to a continuing care retirement community registered before July 1, 2009.**

(b) A continuing care agreement may be terminated for any of the following reasons:

(1) The provider has determined that the resident is inappropriate for living in the care setting.

(2) The resident is unable to fully pay the periodic charges because the resident inappropriately divested the assets and income the resident identified at the time of admission to meet the ordinary and customary living expenses for the resident.

(3) Providing assistance to the resident would jeopardize the financial solvency of the provider and the other residents being served by the provider.

(4) The resident has requested a termination of the agreement as allowed under the agreement.

SECTION 11. IC 23-2-4-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 10. (a) Except as provided by section 11 of this chapter, the commissioner shall require, as a condition of registration, that:

(1) the provider establish an interest-bearing escrow account with a bank, trust company, or other escrow agent approved by the commissioner; and

(2) any entrance fees received by the provider prior to the date the resident is permitted to occupy the living unit in the ~~home~~ **continuing care retirement community** be placed in the escrow account, subject to release as provided by subsection (b).

(b) If the entrance fee gives the resident the right to occupy a living unit that has been previously occupied, the entrance fee and any income earned thereon shall be released to the provider when the living unit is first occupied by the new resident. If the entrance fee applies to

a living unit that has not been previously occupied by any resident, the entrance fee and any income earned thereon shall be released to the provider when the commissioner is satisfied that:

(1) aggregate entrance fees received or receivable by the provider pursuant to executed continuing care agreements, plus:

(A) anticipated proceeds of any first mortgage loan or other long term financing commitment; and

(B) funds from other sources in the actual possession of the provider;

are equal to at least fifty percent (50%) of the aggregate cost of constructing, purchasing, equipping, and furnishing the ~~home~~ **continuing care retirement community** and equal to at least fifty percent (50%) of the estimate of funds necessary to fund startup losses of the ~~home,~~ **continuing care retirement community,** as reported under section 4(12) of this chapter; and

(2) a commitment has been received by the provider for any permanent mortgage loan or other long term financing described in the statement of anticipated source and application of funds to be used in the purchase or construction of the ~~home~~ **continuing care retirement community** under section 4(12) of this chapter, and any conditions of the commitment prior to disbursement of funds thereunder, other than completion of the construction or closing of the purchase of the ~~home,~~ **continuing care retirement community,** have been substantially satisfied.

(c) If the funds in an escrow account under this section and any interest earned thereon are not released within the time provided by this section or by rules adopted by the commissioner, then the funds shall be returned by the escrow agent to the persons who made the payment to the provider.

(d) An entrance fee held in escrow shall be returned by the escrow agent to the person who paid the fee in the following instances:

(1) At the election of the person who paid the fee, at any time before the fee is released to the provider under subsection (b).

(2) Upon receipt by the escrow agent of notice from the provider that the person is entitled to a refund of the entrance fee.

(e) This section does not require a provider to place a nonrefundable application fee charged to prospective residents in escrow.

(f) A provider is not required to place a refurbishment fee of a prospective resident in escrow if a continuing care agreement provides that the prospective resident:

(1) will occupy the living unit within sixty (60) days after the refurbishment fee is paid; and

(2) will receive a refund of any portion of the refurbishment fee not expended for refurbishment if the continuing care agreement is cancelled before occupancy.

SECTION 12. IC 23-2-4-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 12. Any money or property received by a provider as an entrance fee to a ~~home~~ **continuing care retirement community** constructed or purchased after August 31, 1982, or any income earned thereon, may be used by the provider only for purposes directly related to the construction, maintenance, or operation of that particular ~~home.~~ **continuing care retirement community.** A ~~home~~ **continuing care retirement community** in operation on September 1, 1982, may not use the entrance fees or income earned thereon after August 31, 1982, for the construction, operation, or maintenance of another ~~home~~ **continuing care retirement community** constructed or purchased after August 31, 1982.

SECTION 13. IC 23-2-4-13, AS AMENDED BY P.L.2-2006, SECTION 180, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: Sec. 13. (a) There is established the Indiana retirement home guaranty fund. The purpose of the fund is to provide a mechanism for protecting the financial interests of residents and contracting parties in the event of the bankruptcy of the provider.

(b) To create the fund, a guaranty association fund fee of one hundred dollars ($100) shall be levied on each contracting party who enters into a continuing care agreement after August 31, 1982, **and before July 1, 2009.** The fee shall be collected by the provider and forwarded to the commissioner within thirty (30) days after occupancy by the resident. Failure of the provider to collect and forward such fee to the commissioner within that thirty (30) day period shall result in the imposition by the commissioner of a twenty-five dollar ($25) penalty against the provider. In addition, interest payable by the provider shall accrue on the unpaid fee at the rate of two percent (2%) a month.

(c) Any money received by the commissioner under subsection (b) shall be forwarded to the treasurer of state. The fund, and any income from it, shall be held in trust, deposited in a segregated account, invested and reinvested by the treasurer of state in the same manner as provided in IC 20-49-3-10 for investment of the common school fund.

(d) All reasonable expenses of collecting and administering the fund shall be paid from the fund.

(e) Money in the fund at the end of the state's fiscal year shall remain in the fund and shall not revert to the general fund.

SECTION 14. IC 23-2-4-16 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 16. (a) If a ~~home~~ **continuing care retirement community** is bankrupt and the operation of the ~~home~~ **continuing care retirement community** is terminated, the board of directors shall, subject to the approval of the commissioner, distribute from the guaranty association fund established in section 13 to the living residents of the ~~home~~ **continuing care retirement community** an aggregate amount not to exceed one-half (1/2) of the amount in the fund at the time of disbursement. The amount each living resident is entitled to receive shall be prorated, based on the total amount paid on behalf of the resident by the contracting party under the continuing care agreement. In no event may the amount paid to an individual resident under this section exceed the total amount paid on behalf of that resident under the continuing care agreement, less the total value of services received under the agreement.

(b) Any living resident of the ~~home~~ **continuing care retirement community** shall be eligible to receive distributions under subsection (a), regardless of whether any contribution to the guaranty association fund has been made on behalf of the resident.

(c) A resident compensated under this section assigns ~~his~~ **the resident's** rights under the continuing care agreement, to the extent of compensation received under this section, to the board of directors on behalf of the fund. The board of directors may require an assignment of those rights by a resident to the board, on behalf of the fund, as a condition precedent to the receipt of compensation under this section. The board of directors, on behalf of the fund, is subrogated to these rights against the assets of a bankrupt or dissolved provider. Any monies or property collected by the board of directors under this subsection shall be deposited in the fund.

(d) The subrogation rights of the board of directors, on behalf of the fund, have the same priority against the assets of the bankrupt or dissolved provider as those possessed by the resident under the continuing care agreement.

SECTION 15. IC 23-2-4-21 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 21. If the commissioner has reason to believe that a ~~home~~ **continuing care retirement community** is insolvent, the commissioner may petition the superior or circuit court of the county in which the ~~home~~ **continuing care retirement community** is located, or the superior or circuit court of Marion County, for the appointment of a receiver to assume the management and possession of the ~~home~~ **continuing care retirement community** and its assets.

SECTION 16. P.L.3-2007, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE OCTOBER 1, 2008 (RETROACTIVE)]: SECTION 1. (a) **As used in this SECTION, "continuing care retirement community" means a health care facility that:**

(1) provides independent living services and health facility services in a campus setting with common areas;

(2) holds continuing care agreements with at least twenty-five percent (25%) of its residents (as defined in IC 23-2-4-1);

(3) uses the money described in subdivision (2) to provide services to the resident before the resident may be eligible for Medicaid under IC 12-15; and

(4) meets the requirements of IC 23-2-4.

(b) As used in this SECTION, "health facility" refers to a health facility that is licensed under IC 16-28 as a comprehensive care facility.

~~(b)~~ **(c)** As used in this SECTION, "nursing facility" means a health facility that is certified for participation in the federal Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

~~(c)~~ **(d)** As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

~~(d) As used in this SECTION, "total annual revenue" does not include revenue from Medicare services provided under Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).~~

(e) Effective August 1, ~~2003,~~ **2009,** the office shall collect a quality assessment from each ~~nursing~~ **health** facility. ~~that has:~~

~~(1) a Medicaid utilization rate of at least twenty-five percent (25%); and~~

~~(2) at least seven hundred thousand dollars ($700,000) in annual Medicaid revenue, adjusted annually by the average annual percentage increase in Medicaid rates.~~

The office shall offset the collection of the assessment for a health facility:

(1) against a Medicaid payment to the health facility by the office; or

(2) in another manner determined by the office.

(f) ~~If~~ **The office shall implement the waiver approved by** the United States Centers for Medicare and Medicaid Services ~~determines not to approve payments under this SECTION using the methodology described in subsection (e), the office shall revise the state plan amendment and waiver request submitted under subsection (l) as soon as possible to demonstrate compliance with 42 CFR 433.68(e)(2)(ii). The revised state plan amendment and waiver request must provide~~

that provides for ~~the following:~~

~~(1) Effective August 1, 2003, collection of a quality assessment by the office from each nursing facility.~~

~~(2) Effective August 1, 2003, collection of a quality assessment by the department of state revenue from each health facility that is not a nursing facility.~~

~~(3) An~~ **an** exemption from collection of a quality assessment from the following:

~~(A)~~

(1) A continuing care retirement community **as follows:**

(A) A nonprofit organization that is:

(i) exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code; and

(ii) registered under IC 23-2-4 before July 1, 2009.

A continuing care retirement community described in this clause is not required to meet the definition of continuing care retirement community in subsection (a).

(B) A proprietary organization that was registered with the securities commissioner as a continuing care retirement community on July 1, 2003, is not required to meet the definition of a continuing care retirement community in subsection (a).

(C) A continuing care retirement community that meets the definition set forth in subsection (a).

~~(B) A health facility that only receives revenue from Medicare services provided under 42 U.S.C. 1395 et seq.~~

~~(C)~~

(2) A **hospital based** health facility. ~~that has less than seven hundred fifty thousand dollars ($750,000) in total annual revenue, adjusted annually by the average annual percentage increase in Medicaid rates.~~

~~(D)~~

(3) The Indiana Veterans' Home.

Any revision to the state plan amendment or waiver request under this subsection is subject to and must comply with the provisions of this SECTION.

(g) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under this SECTION using the methodology described in subsections **(d) and** (e), ~~and (f),~~ the office shall revise the state plan amendment and waiver request submitted under ~~subsection (l)~~ **this SECTION** as soon as possible to demonstrate compliance with 42 CFR 433.68(e)(2)(ii) and to provide for collection

of a quality assessment from health facilities effective August 1, ~~2003.~~ **2009.** ~~In amending the state plan amendment and waiver request under this subsection, the office may modify the parameters described in subsection (f)(3). However, if the office determines a need to modify the parameters described in subsection (f)(3), the office shall modify the parameters in order to achieve a methodology and result as similar as possible to the methodology and result described in subsection (f). Any revision of the state plan amendment and waiver request under this subsection is subject to and must comply with the provisions of this SECTION.~~

(h) The money collected from the quality assessment may be used only to pay the state's share of the costs for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) as follows:

(1) **At the following percentages when the state's regular federal medical assistance percentage (FMAP) applies, excluding the time frame in which the adjusted FMAP is provided to the state by the federal American Recovery and Reinvestment Act of 2009:**

(A) Twenty percent (20%) as determined by the office.

~~(2)~~ **(B)** Eighty percent (80%) to nursing facilities.

(2) At the following percentages when the state's federal medical assistance percentage (FMAP) is adjusted by the federal American Recovery and Reinvestment Act of 2009:

(A) Forty percent (40%) as determined by the office.

(B) Sixty percent (60%) to nursing facilities.

(i) After:

(1) the amendment to the state plan and waiver request submitted under this SECTION is approved by the United States Centers for Medicare and Medicaid Services; and

(2) the office calculates and begins paying enhanced reimbursement rates set forth in this SECTION;

the office ~~and the department of state revenue~~ shall begin the collection of the quality assessment set under this SECTION. The office ~~and the department of state revenue shall~~ **may** establish a method to allow a facility to enter into an agreement to pay the quality assessment collected under this SECTION subject to an installment plan.

(j) If federal financial participation becomes unavailable to match money collected from the quality assessments for the purpose of enhancing reimbursement to nursing facilities for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the office ~~and department of state revenue~~ shall cease

collection of the quality assessment under this SECTION.

(k) To implement this SECTION, the

~~(1)~~ office shall adopt rules under IC 4-22-2. ~~and~~

~~(2) office and department of state revenue shall adopt joint rules under IC 4-22-2.~~

(l) Not later than ~~July 1, 2003,~~ **August 1, 2009,** the office shall do the following:

(1) Request the United States Department of Health and Human Services under 42 CFR 433.72 to approve waivers of 42 CFR 433.68(c) and 42 CFR 433.68(d) by demonstrating compliance with 42 CFR 433.68(e)(2)(ii).

(2) Submit any state Medicaid plan amendments to the United States Department of Health and Human Services that are necessary to implement this SECTION.

(m) After approval of the waivers and state Medicaid plan amendment applied for under ~~subsection (l),~~ **this SECTION,** the office ~~and the department of state revenue~~ shall implement this SECTION effective ~~July 1, 2003.~~ **August 1, 2009.**

(n) The select joint commission on Medicaid oversight, established by IC 2-5-26-3, shall review the implementation of this SECTION. The office may not make any change to the reimbursement for nursing facilities unless the select joint commission on Medicaid oversight recommends the reimbursement change.

(o) A nursing facility or a health facility may not charge the facility's residents for the amount of the quality assessment that the facility pays under this SECTION.

(p) The office may withdraw a state plan amendment **submitted** under ~~subsection (c), (f), or (g)~~ **this SECTION** only if the office determines that failure to withdraw the state plan amendment will result in the expenditure of state funds not funded by the quality assessment.

(q) If a health facility fails to pay the quality assessment under this SECTION not later than ten (10) days after the date the payment is due, the health facility shall pay interest on the quality assessment at the same rate as determined under IC 12-15-21-3(6)(A).

(r) The ~~following shall be provided to the state department of health:~~

~~(1) The~~ office shall report **to the state department of health** each nursing **facility and each health** facility that fails to pay the quality assessment under this SECTION not later than one hundred twenty (120) days after payment of the quality assessment is due.

~~(2) The department of state revenue shall report each health~~

~~facility that is not a nursing facility that fails to pay the quality assessment under this SECTION not later than one hundred twenty (120) days after payment of the quality assessment is due.~~

(s) The state department of health shall do the following:

(1) Notify each nursing facility and each health facility reported under subsection (r) that the nursing facility's or health facility's license under IC 16-28 will be revoked if the quality assessment is not paid.

(2) Revoke the nursing facility's or health facility's license under IC 16-28 if the nursing facility or the health facility fails to pay the quality assessment.

(t) An action taken under subsection (s)(2) is governed by:

(1) IC 4-21.5-3-8; or

(2) IC 4-21.5-4.

(u) The office shall report the following information to the select joint commission on Medicaid oversight established by IC 2-5-26-3 at every meeting of the commission:

(1) Before the quality assessment is approved by the United States Centers for Medicare and Medicaid Services:

(A) an update on the progress in receiving approval for the quality assessment; and

(B) a summary of any discussions with the United States Centers for Medicare and Medicaid Services.

(2) After the quality assessment has been approved by the United States Centers for Medicare and Medicaid Services:

(A) an update on the collection of the quality assessment;

(B) a summary of the quality assessment payments owed by a nursing facility or a health facility; and

(C) any other relevant information related to the implementation of the quality assessment.

(v) This SECTION expires August 1, ~~2009.~~ **2011.**".

Delete page 3.

Page 4, delete lines 1 through 14.

Page 4, line 16, delete ""advisory committee" refers to the health policy" and insert "**"committee" refers to the Medicaid managed care quality strategy committee created by this SECTION.**

(b) the Medicaid managed care quality strategy committee is created to provide information on policy issues concerning Medicaid. The committee shall study issues related to the following:

(1) Emergency room utilization.

(2) Prior authorization.

(3) Standardization of procedures, forms, and service descriptions.

(4) Effectiveness and quality of care.

(c) The members of the committee shall include at least one (1) individual representing each of the following:

(1) Medicaid providers.

(2) Public hospitals.

(3) Medicaid managed care organizations.

(4) Mental health professions.

(5) The office of Medicaid policy and planning, who shall act as chairperson of the committee.

(6) Other state agencies.

The governor shall appoint the committee members. The committee may not consist of more than seven (7) members.

(d) The office of the secretary of family and social services shall staff the committee.

(e) The affirmative votes of a majority of the members are required for the committee to take make recommendations.

(f) Before October 1, 2009, the committee shall report to the select joint commission on Medicaid oversight established by IC 2-5-26-3 concerning the committee's recommendations.

(g) This SECTION expires December 31, 2009.".

Page 4, delete lines 17 through 42.

Page 5, delete lines 1 through 41.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1572 as printed February 20, 2009.)

MILLER, Chairperson

Committee Vote: Yeas 7, Nays 0.

SENATE MOTION

Madam President: I move that Engrossed House Bill 1572 be amended to read as follows:

Page 14, delete line 42.

Page 15, delete lines 1 through 6.

Page 15, line 7, delete "(B) A proprietary organization" and insert "**(A) A continuing care retirement community**".

Page 15, line 9, delete "July 1, 2003," and insert "**January 1,**

2007,".

Page 15, line 12, delete "(C)" and insert "**(B) A continuing care retirement community that, for the period January 1, 2007, through June 30, 2009, operates independent living units, at least twenty-five percent (25%) of which are provided under contracts that require the payment of a minimum entrance fee of at least twenty-five thousand dollars ($25,000).**

(C) An organization registered under IC 23-2-4 before July 1, 2009, that provides housing in an independent living unit for a religious order.

(D)".

(Reference is to EHB 1572 as printed April 10, 2009.)

MILLER